Deposition of:

Daniel Silcox III , M.D.

August 17, 2016

In the Matter of:

Walker vs. Mac Acquisitions

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

DAVID G. WALKER and
SANDRA R. WALKER,
Plaintiffs,

vs.

Civil Action File No.
1:14-cv-04035-CC

MAC ACQUISITION, LLC,
Defendant.

VIDEOTAPED DEPOSITION OF DANIEL H. SILCOX, III, M.D.

August 17, 2016 - 4:35 p.m.

5505 Peachtree Dunwoody Road

Suite 600

Atlanta, Georgia

J. David Brown, B-1401

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(Pursuant to Article 10(B) of the Rules and Regulations of the Georgia Board of Court Reporting, a written disclosure statement was submitted by the court reporter to all counsel present at the proceeding.)

P R O C E E D I N G S

THE VIDEOGRAPHER: This is the videotaped deposition of Dr. Daniel Silcox in the case of David Walker and Sandra Walker versus MAC Acquisition, LLC. Today is Wednesday, August 17th, 2016 and the time is 4:35 p.m. We're now on the video record.

All counsel present, please introduce themselves and state whom you represent.

MR. DEVINE: My name is Foy Devine and I represent David and Sandy Walker.

MR. BAKER: My name is Kyle Baker. I represent the plaintiffs as well.

MS. TAYLOR: My name is Melanie Taylor and I represent the defendant, MAC Acquisitions.

THE VIDEOGRAPHER: You may now swear in the witness.

DANIEL HAL SILCOX, III, M.D., having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. DEVINE:

Q. Dr. Silcox, would you give us your full name for the record, please.

A. Daniel Hal Silcox, III.

Q. And where did you grow up, sir?

A. I grew up in Gainesville, Georgia.

Q. Could you just briefly give us an overview of your formal education.

A. I received my bachelor of arts degrees at Emory University or Emory College of Emory University in 1983. Completed my medical doctorate degree at Emory University in 1987. Completed one year general surgery internship with the Emory affiliated hospitals in 1988 and then finished my orthopedic surgery residency training in 1992 and that again was at the Emory University affiliated hospitals.

Practiced one year on the faculty at Emory University School of Medicine and the Emory Clinic. And then did a one-year spine surgery fellowship again at the Emory University affiliated hospitals. Completed that in 1994. And I'm board certified by the American Board of Orthopedic Surgery. Was originally in 1995. Been recertified two other times. And I'm certified through 2025.

(Plaintiff's Exhibit 1 marked)

BY MR. DEVINE:

Q. Before you is a document that's marked as

Plaintiff's Exhibit 1 for Silcox. Do you recognize that document?

A. It is my curriculum vitae. And it needs updating but it is January 1st, 2015. And otherwise it is accurate.

Q. What additions would need to be made to bring it up to date?

A. Some speaking and in-progress research.

Q. What is your area of specialty within medicine?

A. Orthopedic spinal surgery.

Q. And could you tell the jury in a little bit more detail what you do as an orthopedic spinal surgeon.

A. So I treat all disorders of the spine. Those could be infections, tumors, fractures, degenerative processes which include something called spinal stenosis as well as disc herniations, deformities such as scoliosis, and other deformities that probably are esoteric and not necessarily. But all forms of spinal problems both surgical and mainly nonsurgical.

Q. And in this particular matter what area of your expertise came into play with regard to David Walker?

A. So I treated Mr. Walker for a cervical spine problem or a neck problem. And how specific do you want me to get with that? I'm sure you're going to ask me other questions.

Q. Yeah. I'll elaborate on that. When did you first -- and feel free to refer to any of the medical records that you have here at Peachtree Orthopaedic Clinic -- but when did you first see Mr. Walker?

A. I first saw Mr. Walker July 26th, 2013.

Q. And how did he come to be a patient of yours at that time?

A. He was a second opinion consultation that was requested by one of my partners, David Schiff.

Q. And what did you understand the nature of Mr. Walker's issues to be?

A. He was complaining of right upper extremity numbness and pain.

Q. And by that would be the right arm, shoulder? What does right upper extremity mean?

A. That would include anywhere from the neck going down through the shoulder and down the arm to the hand. He also had a complaint of neck pain as well.

Q. Were you able to review the records to

determine what sort of treatment he'd received for that condition and for how long?

A. Yes. And my note does not tell me how long as far as some of the treatment. But he had utilized physical therapy, massage, he had had I believe two epidural steroid -- excuse me, two steroid packs as well as epidural steroid injections. I'm not quite clear as to the number of epidural steroid injections. I'd have to look back through the notes to verify that.

But he had undergone what we would consider to be appropriate treatment for his complaints and those are somewhat algorithmic, so you start with the simplest and you start moving to the more elaborate. And he was coming to me because he had failed to improve with those conservative types of treatment and Dr. Schiff wanted to see if surgery was an appropriate option for him.

Q. And what did you do to answer the question as to whether surgery was an appropriate option?

A. So the decision to have surgery is based on the patient's symptoms and then also the objective findings which include physical exam

findings as well as those of plain x-rays and MRIs. And so I put him through the physical examination and found that he had some findings consistent with irritated nerve roots on the right side of his cervical spine.

Specifically in my notes are something called a Spurling sign which is when we lean the patient's head back and then tilt it to the side. And what that does is it actually closes down the passageway for some of the nerves. And if it recreates their pain, that is indicative of someone that has an irritated nerve root.

He also had some decreased sensation in the right arm in the area of the C6 and C7 nerve roots which basically are these fingers here, a little bit of the fourth finger. So a very predictable pattern of complaints that fit with the subsequent findings of the MRI which were of what we call disc osteophyte complexes. That's a term to say that there's some bone spurs and bulging discs that were narrowing the passageways for the nerves on the right-hand side at the C5-6 and C6-7 levels. And you can interject questions as you like in there.

Q. The next question I had is do you have

any MRIs that are available to you to help illustrate or help the jury better understand what was going on with Mr. Walker at this time?

A. So I do have an MRI from June of 2013. If you can bring that up.

Q. Tell us what an MRI is while we're doing that.

A. So MRI means magnetic resonance imaging. It is basically is a powerful magnet that makes the atoms -- and I won't get into the specifics -- in our body kind of change direction so that -- anyway it creates a picture of the inside of the body.

Q. You want to pull up the particular image that you believe will help you to better explain what was going on with Mr. Walker in June of 2013.

A. So this is the MRI of Mr. Walker dated June 12th, 2013. And so can the jury see the picture I'm looking at right now?

Q. Yes. And where you show the cursor, it serves as a pointer.

A. So this is actually the tongue of Mr. Walker. This is underneath of his chin, the front of his neck. This goes down to his chest, so this is the back of his neck. So it is a side view. These are the bones in the neck: C2, C3,

C4, C5, C6, C7. So there's seven cervical vertebrae. The first one is very hard to see for almost everyone on an MRI. And then these are the thoracic vertebrae down here.

This is the spinal cord, this dark structure that looks like a long snake. The very bright white around it is called cerebrospinal fluid. So the spinal cord and the brain, and this is part of the brain called the cerebellum, are all floating in this fluid.

The discs are the dark areas in between the bones. And so the white fluid gives an excellent contrast to see if any disc is actually protruding out. And what we can actually see here -- and I'll enlarge this -- is that this is C5 and this is C6. You can see how the disc bulges out some here. Bulges by themselves are not particularly worrisome and they're part of the aging process.

As we go to the -- and I'm actually moving the picture and this is slicing through the spine from left to right, so I'm moving towards the right. You can see the bulge gets a little bigger. And I get out here and you can see bulge of disc. And when I said disc osteophyte, you can see how

there's a little white spike of bone because again this is the C7 vertebra. This is C6. There's also a little spike of bone off of C6. And then there are also little bones here at C5-6.

The dark here is either disc material or it is bone, but it appears to be more disc-like given the fact that you can see very clearly a bone spur. But that's going off to the right. And if we go even further, you can still see this is getting out into what's called a foramen which is a hole that a nerve exits out of.

So we'll look at this other picture on the other side. This is a little harder for most people to understand, but I already told the jury that this area here is the spinal cord and the white around it is fluid. So this is a cross-sectional view. This is Mr. Walker -- looking at Mr. Walker's neck as if we could cut him in two and look up towards the top of his head. So this is the front of his body, this is the back of his body, this is the right, and this is the left.

And so if we're looking at this, this shows where a nerve is coming out on the right and where a nerve is coming out on the left and the spinal cord is floating in this fluid. And this

looks completely normal here. This is up very high in his neck.

As we come down we'll see other areas where the nerves are exiting out. This is at C3-4, so that's the space between the third and the fourth bone. And we'll come down to C4-5 which is here and we can see the spinal cord. It looks a little bit different. It is not quite as oval as it was above. There's a little bit of narrowing over on the right-hand side and that, again, is probably a bone spur. It is fairly small.

We'll come on down further and we'll get to C5-6 and we'll see that this level there's more bone spur all over here on the right-hand side and there's even a little central bone spur or bulge of the disc that causes the spinal cord to look like it is a little kidney bean maybe instead of a nice oval shape. I'll go back up to where it looks completely normal, it is oval shaped there. Come back down to this and it looks a little like a kidney bean.

So we come down further to C6-7 and now you can see there's actually a large disc or bone spur protruding on the right-hand side. Again, this is the right, this is the left. The spinal

cord is a little bit compressed and displaced there. And then as we come down further it opens up although there's a little bone spur also seen at C7-T1, so that's the space between the end of the cervical spine and the beginning of the thoracic spine.

Q. Now, were his complaints more on one side than the other? And if so, which?

A. So again, he presented with complaints of neck pain and right upper extremity numbness and pain. And so this right-sided pathology or problem is consistent with his complaints. And even more so the C7 nerve root comes out through this hole that's narrowed at C6-7. And if I go back up to the C5-6 level, the narrowing here and what looks like maybe even a disc herniation there, the C6 nerve root would be irritated at that level and he also has symptoms as well as decreased sensation in the distribution of the C6 nerve root.

So ultimately his physical exam findings correlated with irritation of the C6 and the C7 nerve roots on the right-hand side and he had radiographic, which meaning the MRI, findings that were consistent with his complaints. So with those findings and with his history of having failed to

improve with conservative care as well as his ongoing symptoms of pain, surgery was an option for him in order to get long-term relief of his symptoms.

Q. What were his other options in say this time frame June, July, August of 2013?

A. So in the most simplistic way he really exercised all options other than continuing to do physical therapy exercises on his own which because at some point seeing the therapist really outlives its practicality. And/or what that means is basically live with it and just tolerate pain and, you know, that is an option for everyone.

Q. And what advice did you give him regarding the possibility of going forward with surgery after you had done the workup on him?

A. I'm not certain what you're asking.

Q. Well, basically after you had done the workup with him and said what his options are, did you give him any advice or how does that work? How did that work with Mr. Walker?

A. So I tell all my patients I can't feel your pain, so it is really up to them. If their pain -- my goal is to educate them as to what I can do and then it is up to them to decide whether they

wish to proceed with surgery or not. And that's going to be dictated based on your symptoms. So if your symptoms are bad enough, I presume you'll choose to have surgery. If your symptoms are not, then my guess is you'll come see me if you need me.

Q. I think your notes show at some point you essentially gave him that option. And what did he ultimately decide to do?

A. Ultimately he decided to have surgery.

Q. Have we looked at any videotape that fairly and adequately shows the type of surgery that you were proposing for and ultimately did on Mr. Walker in early August of 2013?

A. We have.

Q. I am going to bring up clip number 1 from the surgery and ask you to -- well, first let me ask you before you start, have you had a chance to look at this video and determine whether it fairly and adequately represents the kind of surgery you did with Mr. Walker?

A. I have. Although what it will show is a single level surgery and he had a two-level surgery.

Q. Well, with that variation does this video fairly and adequately show the type of surgery that

you did with Mr. Walker?

A. Yes.

Q. Let's go ahead and start the clip.

A. Would you like me to narrate?

Q. Yeah. Tell us if you will what we're looking at.

A. So we are looking at the front of the cervical spine minus all the muscles, arteries, veins, the esophagus, trachea, all the other things. So we're looking at just the bony anatomy. And then you can see the disc I guess again my cursor shows up here.

Q. Yeah, your cursor will show.

A. These are the disc spaces. This is considered a relatively normal disc, normal disc, and then this disc has degenerative changes. The disc is not as tall. These kind of areas that look like little undulations are actually bone spurs on the front of the spine.

Q. Let's roll and you continue to tell us what we're looking at.

A. So we're getting a closeup view. These are little pins that are put into the bone to be able to then distract or spread apart the disc space.

Q. And what's the purpose of that?

A. So as you can see, it is a -- well, it is a very small space. Most discs are anywhere from 4 to maybe 7 millimeters in height normally. As the bone spurs and all are created, that space gets even more narrowed. So we distract the bones to open up the space so we can do the surgery to be able to remove the disc material.

Q. We'll roll on. Oops, I hit it too hard. Let's let it roll to the end of the clip. Let's do the second clip then.

Tell us what we're looking at here. Go ahead.

A. So go ahead. Yeah. Hit that and we'll -- so this simplifies the surgery as if we could just pick the disc out. You actually have to excise it. And then that showed the disc having been removed. This is an actual intraoperative picture. This is not Mr. Walker. This is another patient from Dr. Cornman?

Q. Cornman I think it is.

A. I'm Southern. I've got marbles in my mouth, so it is sometimes hard for me to say things.

Q. Can you tell us what we're looking at

here.

A. So he's actually excising the actual disc material. So what you're looking at, this is actually the bone of C5 I believe in this case and this would be C6. The disc material is in here. And as he moves it, you'll be able to see it is soft tissue. The disc is soft tissue. You can see the soft tissue moving. He's using a scalpel blade to actually cut that out. And then he'll use what's called a pituitary rongeur to grab the disc material and remove it.

This is the animated version of showing removal of bone spurs. And then he'll actually show dusting off those bone spurs. This is a little out of order since he already removed disc material. So typically you can remove the bone spurs when you like. I usually do it towards the end of the surgery, not at the beginning. So that is showing now the disc is completely bone. He's going to --

Q. What is this instrument being used?

A. This is a drill with a little it is a cutting burr on the end. It actually is going to be able to level out the bone so that the bone graft material used in this particular surgery can

be set into the disc space. Because obviously once you remove the disc, something has to go back in place of it. So in this case they're going to take a piece of bone and put in there.

And you want a flush fit between the pieces of bone that exist, namely Mr. Walker's bone in his case, and then the pieces of bone will fit flushly to his bone and the artificial bone or the bone from the patient or in the case of Mr. Walker a plastic polymer spacer will fit flushly to the bone, so keep going and we'll see that.

So again they're dusting off the edges of the bone. He's going to do some more work. I use a different instrument to do this but the result is the same and that is burning off the ends of the bone and then taking off the last bit of cartilage, cartilaginous material in the back of the disc.

Q. Then we'll pick up with the third clip.

A. So I think in this particular case he's using probably at this point a diamond burr. So that's like a very, very fine sandpaper. It is hard for me to tell for certain because the burr is moving. But he's preparing it and he's going to trial at some point here a spacer.

Q. What's going on?

A. He's irrigating there to get rid of what we call the treatis, that is the little shavings and all, you want to get those out of there because they're not viable at that point and it decreases the risk for infection if you'll irrigate that out and get it cleaned out. So he's just sucking up the irrigant.

Q. Now, what's the white in the bottom of this picture?

A. So this looks like some residual disc material. So as a surgeon I'm not certain what the initial pathology was, that is the reason for this surgery. But I wouldn't actually clean all this out myself. I would leave that back there. But again, I don't know exactly what the reason for the surgery was other than it looked like it was an unstable disc space. He's going to take a trowel which is a metal piece and he's trying to size what size piece of bone needs to actually go in there. So again, these are pieces of disc. I do not see the spinal cord actually exposed through his surgery.

Q. So the spinal cord is below that?

A. Yeah. So this looks like the posterior longitudinal ligament. It is a ligament on the

back of the spine that's in between the spine and the spinal cord. This just depicts the spacer going in there, the trial spacer, and it is trying to match his normal disc height after having burred off the bone itself.

Q. It says Proper Distraction there. What does that mean?

A. So again, trying the match up the height of the disc space to a more normal-looking disc. But obviously he's flattened out the bone so it will not be wedge shape like the normal disc. It will be more block shape.

So this is the surgeon putting in the piece of bone and he's actually using a small hammer to impact it into the disc space. But this was the point I was trying to make. Again, this is a tamp. So he's actually pushing it into the disc space. But you can see the flush fit between the two bony surfaces. That looks very nice.

Q. What are we looking at here?

A. So this is a titanium plate. So these bones have to grow together. And bones heal better if they're not moving independently. So that hence, if you break your arm, you're put into a cast or your leg, you get a metal plate and screws.

You hold the two broken ends of the bone together so they'll grow together. And likewise, in a fusion this is holding the bone above and below still to allow this bone graft to incorporate into the existing bone.

Q. And what affixes the plate to the bone?

A. The screws. So this green here is a screw that's being placed into the vertebral body of C6. And it will take four screws, two into C6 and then two screws will go into C5.

Q. And in Mr. Walker's case how would you compare this plate to the one you used in his surgery?

A. So similar except for obviously this is just immobilizing two bones and he had three bones immobilized, so there would be a longer plate with two extra screw holes.

Q. What's the function of the round piece?

A. In the middle here?

Q. In the middle there, yeah.

A. That's a locking mechanism. So once these screws are in, they will tighten this down and it will -- there's a little ring there that will actually lay over the screws that were put in to lock them in so they can't back out. Now, I say

can't back out. Except for what, death and taxes, nothing is guaranteed. So screws can still back out in spite of that nice little invention.

Q. Now, do you know whether you have an image that shows postsurgically what Mr. Walker has in his neck after you finished?

A. So we have an MRI from ...

Q. I think we're pulling that up for you here.

A. So this is a follow-up MRI dated July 13th, 2015, so almost two years from the time of his surgery. And so we get similar images to what I was showing the jury before. So here we have this same image of the slice. So here's the spinal cord again, here are the vertebra. And so disc spaces in between and now you can see this is C5. This has turned into bone C6 and then C6-7 has turned into bone. The protruding discs are completely gone back here although he does have a -- at that time he was having some other symptoms and he had a disc herniation below at C7-T1.

Q. I'll get into those in just a minute. Do we have an image that shows the plate that you put in during the surgery?

A. Well, this does. You have to -- we

probably do have a plain x-ray, yeah. I don't know that this will show the -- let me find one here that will be ...

Q. I think that may be it.

A. I was trying to get one a little further out. This shows the little plate that's, as I said, encompasses three levels. So this is the screws into C5, 6, and 7. And this particular picture is about six months after his surgery, so you can see how this is turning into bone inside of the disc space.

I think I have one other picture that may be a little bit farther down the line. Extra pictures in here. So this actually shows the subsequent fusion that formed how this has completely turned into bone. So the little spacers or these little markers, the plastic does not really show up otherwise because it is plastic. The metal screws otherwise are shown in the bone and then, as I said, the bone that's been formed and joined together C5, C6, and C7. So this is a successful fusion.

Q. What's the date of the image you're looking at now, Doctor?

A. August 12th, 2014, so it is right at a

year after his surgery.

Q. Now, you mentioned a moment ago that after the surgery you followed him and what did you find was the results of the surgery?

A. So he had improvement following surgery. I have to kind of dig through notes here. So it looks like follow-up notes from September 11th, 2013, which was right after surgery, he was doing relatively well at that point. Kind of some normal postoperative complaints, still hurting some but his right upper extremity pain was gone. He was just having mainly neck pain at that point.

On October 23rd, 2013, which is a three-month follow-up visit, he continued to have some posterior neck pain and pain in his trapezius which are these muscles up on the shoulders. He was noticing his range of motion was picking up. And we basically were making him go to physical therapy to improve his range of motion.

January 15th, 2014, which is one of the x-rays I showed postoperatively, showed his fusion to be healing well. He was forming bone well. And as far as symptoms go, it says that the pain he had had in his neck and his trapezius region had eased up a bit. That was my PA dictating that. That's

maybe loose vernacular for being better.

And then I think we changed to a different record system, so give me a second to find the note there. Apologize. These are not easy to rifle through.

I tell you what, I'm going to paraphrase because it is hard to find the dates on all these.

Q. All right.

A. So by and large he did continue to improve. The one year follow-up I believe he was doing reasonably well. And then he began to have some increased symptoms of neck pain I believe late in two thousand -- I have to look back here at the date. May have been early 2015. Subsequently though he had that other MRI done.

Q. In July of 2015 I believe you said.

A. Or it may have been in August. Anyway but it was about two years out from his surgery.

Q. Right.

A. And we got an MRI which showed him to have developed a disc herniation at the -- has this got the date? Yeah. It was July 13th, 2015, so almost two years out from his surgery and he had developed a small disc herniation at C7-T1.

Q. Now, tell me what that comes from in your

opinion, Doctor.

A. So he did not report any particular injury so --

Q. In 2015?

A. Correct. So one would have to assume that to some degree the preexisting degenerative changes put him at an increased risk for subsequently through an attritional kind of just wear and tear process he got that small disc herniation. And he did I believe receive an epidural steroid injection from my partner David Schiff at that time.

Q. And we're going to ask him about that. In your experience is there any effect at all on adjacent joints above and below where a fusion occurs?

A. So the -- yes, there is. And the medical literature would suggest that there is a risk that's probably in the 10 to 15 percent, maybe even some reports would be even higher than that, 20 percent chance that you can get adjacent segment degenerative change, maybe symptomatic, maybe not symptomatic.

So we know that does happen. As to why it happens is still unclear because -- but there

are artificial discs that exist which retain motion and yet people wear out above and below artificial discs as well, so there appears to be some genetic component that's part of this. So we don't know for certain why people will wear out although I think a lot of us feel the stiffness of a fusion probably does push the risk to wear out above or below but it is not clearly understood.

Q. You mentioned symptomatic and nonsymptomatic. What do you mean by those terms, if you would elaborate?

A. So again, degenerative changes occur with everyone. I got gray hairs, you have some. There's a few others who may have some and then a lot of people who don't. But the point being is we all degenerate, we all wear out. So x-rays document that well. But that doesn't mean you necessarily hurt. So someone who is asymptomatic doesn't hurt but does have degenerative changes. It does also in part the fact that they're perhaps more likely to be injured than someone who doesn't have degenerative changes.

Q. Tell me what you mean by that, someone who's got degenerative changes is more likely to suffer or be hurt than one who doesn't.

A. Well, I think logic would dictate that to a great degree. I think when you and I talked earlier I said we don't see old football players playing because they get injured more easily. And why is that, it is just the wear and tear change to their body through the years they're more susceptible to being injured. Now, granted they're playing football. But it even goes for those of us if I go out at age 55 and start doing some really hard yardwork, I'm more likely to herniate a disc in my back by just doing yardwork than my 19-year-old son and that's because I'm wearing out for better or for worse. So we just have to keep that in mind that as we age and we have degenerative changes, we are more prone to injury.

Q. Now, Mr. Walker in March of 2013 was in his mid forties. Based on the view of his images of his spine, was he in your view have more or less or about normal level of degenerative changes for someone his age?

A. Relatively normal.

Q. You are also familiar I assume with the fact that he'd had some history of problems including even a surgery in his low back or lumbar area down by his waist?

A. I was aware of that, yes.
Q. How would that relate to, if at all, the problems that he presented with in 2013 that you saw him for after Dr. Schiff had seen him?
A. The lower back?
Q. Yes. How would the low back issues and surgery, how would that affect someone with the neck issues that he presented with?
A. I really wouldn't tie the two together. So lumbar disease is -- granted you can have lumbar degenerative disc disease in there or have degenerative changes in the cervical spine. But as far as the injury and pathology in the lower back, it is so far removed from the neck there really isn't a tie-in other than the genetic predisposition that may exist for degeneration just because of what your mom and your dad gave you.
Q. Right. Now, approximately how tall was Mr. Walker when you first encountered him as a patient?
A. 5 feet, 11 inches was the height he had when I first saw him.
Q. And the weight?
A. 218 pounds.
Q. Let me ask you to assume that in March of

2013 that Mr. Walker went through a door at a restaurant. As he opened the door his first footfall beyond the door his foot went out from under him, he found himself essentially up in the air, both feet up in the air, and he landed in a way that he was trying to protect his lower back or his lumbar back and describes his feet and upper body hitting the floor and him being able to keep his lower body or his rump if you will from not striking the floor and experiencing something like whiplash in the neck.

Now, how would that in your opinion relate to the kind of symptoms that he had when you first saw him in June of 2013?

A. So I think we have established that he had preexisting degenerative changes. And if we have not, he did. Plain x-rays showed some typical degenerative changes. I'll step out. I did find from the other attorney here that there was an MRI from 2009 that did show degenerative changes in the cervical spine which were seen again in the MRI from June of 2013. These produced foraminal stenosis so some narrowing of the passageway where the nerves are coming out at the C5-6 and C6-7 levels.

So in the case of falling and whiplash where the head is thrown backwards, other times it is thrown forward and then backwards. But in that process a narrowed hole can become even more narrowed. Just like I said earlier, one of our examination things is Spurling maneuver where we had the patient lean his head or her head backwards and then tilt it to the side, we're closing down that hole.

If you do that acutely with some minor trauma which is essentially the slip and fall, it can pinch the nerve root and in doing so, if it is hard enough, create a swelling of the nerve in this little hole. Very similar to having a ring on and then slam your finger in the door, your finger begins to swell up. If you go to the emergency room, they're going cut that ring off very quickly because the swelling will be only aggravated by the fact that there's something obstructing the blood flow in and out of the finger.

Much is the same here, the blood flow within that foramen, that little hole, begins to change as the nerve swells and it is that change in the blood flow that then produces a chemical change in the nerve. I'm trying to simplify that. But

that's what induces the pain in his arm. That can also occur when someone herniates a disc and that disc fills up a space which was before open for the nerve to move in.

And again, what's it do? It creates inflammation and a change in the blood flow. Hence, that's why antiinflammatory medications are used intended to shrink that inflamed and swollen tissue. Steroids are then tried if those antiinflammatories don't work again to shrink the inflamed tissue. And then an epidural steroid injection is putting the steroids right where the problem is, again, to help shrink the inflamed tissue all to help improve the blood flow in the nerve root so it can return to feeling normal. And of course if it won't return to being normal, then that's when the patient ends up looking at surgery.

Q. Assuming the kind of fall that I described to you occurred, how quickly would pain or injury begin to be noticed by the person who experienced that fall if in fact some injury occurred?

A. It could be anywhere from, you know, relatively instantaneous to it could be a few days or a week or so down the road. It just depends on

how much obstruction of the blood flow and compression in the nerve occurs acutely versus over time. And again, you know, I don't know that I can be anymore precise than that but that's just the kind of way it works.

Q. If the record shows that the fall occurred on March the 3rd and his first visit with Dr. Schiff regarding this fall was on March the 12th, would that be unusual from your standpoint or within the norm? How would you characterize that?

A. I am going to assume he called for an appointment since we're not an emergency room, so that would have taken a few days. So the chronology events are such that you're injured and you call for an appointment with an doctor you have already seen and you get in as soon as I can. And I think Mr. Walker would have to answer to that as to how quickly he could get an appointment.

Q. Going now to his current situation or at least when you last saw him in 2015, what was his condition then and what were his options as you found them and shared them with Mr. Walker?

A. So he was still having some symptoms. And I'll try to see -- let's see. Let's see if I

can find my note here. You probably have it --

Q. July 2013 was the date of the MRI -- I'm sorry, July the 13th, 2015 was the date of the MRI that we looked at earlier that was about two years after the surgery.

A. Yeah, it looks like I saw him on ...

MS. TAYLOR: You want me to give him my copy?

MR. DEVINE: Yeah, if you've got one handy.

A. With our new electronic medical record it is very difficult to find notes.

MS. TAYLOR: I think I just found it.

A. Well, this is the, yeah, the MRI report is July 13th. And then it looks like I saw him on -- my goodness, trying to find a date on these is very difficult.

BY MR. DEVINE:

Q. I think we may be able to find them on the computer here.

A. It is 8/3/2015. I finally found it.

Q. August the 3rd, 2015.

A. Is when I saw him and that was to follow up on his MRI. And at that time I talked to him about the fact that he had the disc herniation at

C7-T1 on the right. And so this is somebody pulled it up for me.

Q. Yeah, we've pulled it up for you to --

A. Go back over.

Q. -- show the jury what was going on in July of 2015.

A. So when we look at this -- so this is a little easier to -- this is the side view again -- shows the fusion that was done. And as I go over towards the center, you can see down here at C7-T1 this is an acute or relatively subacute, meaning not necessarily yesterday but within a month or two, that this is a new disc herniation here at C7-T1.

And the reason we can tell that is it is kind of a lighter gray versus the black that the other disc material and/or the bone here and that means it has got some inflammation in it. This cross-sectional view is easier to see here because it shows the teeth and his jaw. So again, this is front, this is back, right, left.

And as we come down to this disc level and you can see part of his fusion here. We get down to C7-T1. And again, this is the right side, this is the left side. You can see this protrusion

or herniation that is on the right-hand side at C7-T1.

Q. What are now and have been since you saw him in July and August of 2015 are options for Mr. Walker to deal with this disc herniation at C7-T1?

A. So at that time I believe I offered up to him to get an epidural steroid injection with Dr. Schiff. And then I think he did have a nerve test done also with Dr. Schiff. The long and short of it, I ended up telling him if he was bothered by his symptoms enough, then additional surgery could be done either as a what we call laminoforaminotomy because the disc herniation is off to the side and in an attempt to avoid a fusion at that level we could just take the disc herniation out and open up the little hole for the nerve or the other would be to look at a fusion at the C7-T1 level. So either type of surgery would help relieve his pain.

And again, the decision to have surgery would be based on his symptoms as well as the findings that were then --

Q. Right.

A. Of course at this point he's far enough out he would need to have a new MRI to verify that

it is still reasonable to undergo surgery.

Q. Did you think that surgery was a reasonable option for him as early as August of 2015?

A. I think in August 2015 I was like try the epidural first --

Q. Right.

A. -- because symptoms can resolve.

Q. Right.

A. If they did, then no surgery would be necessary.

Q. Do you have an opinion as to whether the disc herniation at C7-T1 that he's currently dealing with has any causal connection to a fall on March the 3rd, 2013 at the restaurant?

A. There was a previous little bone spur out here on the right. But in comparing to two MRIs, this is a noticeable change that occurred. So I cannot say directly it was caused by the fall of whatever the date was, March of 2013.

Q. March the 3rd of 2013. But in terms of the symptomatology that he's experiencing and the surgery that you did to deal with that, is there any causal connection in your opinion between those?

A. This is probably one of the most debated points of medicine is is the adjacent segment disease due to the fusion or not. And it is possible. I cannot say that it is probable but I can say it is possible.

Q. Now, insofar as what his choices are as we sit here today, assume for a moment that he has tried the steroid injection and had the nerve test done and we'll talk with Dr. Schiff about that. But what would his options be going forward assuming that he had another MRI and it showed what we're looking at as of July 2015, that the MRI confirmed that he still had that condition, what would his options be now?

A. Really the same as I said before. So he could look at a lamino -- I mean he could have epidural steroid injections again, physical therapy is still available. I mean he can redo those conservative forms of treatment. Or if he opts to move forward since he's at least had one epidural, he could always elect to undergo further surgery if he wished to do so.

Q. Or?

A. Live with it.

MR. DEVINE: Thank you, Doctor.

EXAMINATION

BY MS. TAYLOR:

Q. Hi, Dr. Silcox. Again, I'm Melanie Taylor and I just have a few questions for you. You gave us a tour of Mr. Walker's discs and bulging discs and nerves and bone spurs. You're not saying that any of those conditions were caused by the fall at Macaroni Grill, correct?

A. And I think you and I talked about this earlier is without me doing a head-to-head comparison, my impression is more likely than not the changes are more degenerative in nature although there could be acute herniation at C5-6. But I'd have to do head-to-head comparisons and I've not had the opportunity to do that.

Q. Because your first time seeing Mr. Walker was after his fall, correct?

A. It was.

Q. And your note on July 26th states that the patient told you that his symptoms started after the fall, correct?

A. Correct.

Q. You did not independently attempt to verify that or challenge it, correct?

A. That's correct.

Q. And you were not informed at that time about any similar symptoms that Mr. Walker might have had in 2009, correct?

A. I was not aware of any.

Q. Nor were you informed about any similar symptoms that he had in 2010, correct?

A. Correct.

Q. And how about 2011?

A. Correct, I was not aware of any.

Q. And the purpose of your evaluation and treatment was not to determine whether his fall caused his symptoms or injury, correct?

A. That's correct.

Q. For the purposes of your treatment you did not need to confirm that his symptoms started after the fall, right?

A. Correct.

Q. So you did not need to nor did you request medical records from the years prior to his coming to you, correct?

A. That is correct.

Q. And you did not compare his MRIs from before the fall with those of after the fall, correct?

A. I was not aware there was one before.

Q. So all of that is to get to this: You did not personally confirm whether Mr. Walker had any of these symptoms or diagnosis before the fall, correct?

A. That is correct.

Q. So in fact if Mr. Walker did have neck pain or finger numbness before the fall in 2013, you would not know that, right?

A. You're correct.

Q. And Mr. Walker has not returned to you for treatment since October 8, 2015, correct?

A. That is correct.

MS. TAYLOR: I have no further questions.

EXAMINATION

BY MR. DEVINE:

Q. I have some redirect, Doctor. In terms of confirming the existence of symptoms at certain points in time, how would a doctor go about doing that?

A. Number one, I would have to explore that. Number two, I would have to have -- and we even talked about this before -- if I know I'm going to be doing a deposition two or three years later, I probably would have asked the questions differently. But I have to admit I think as a

doctor and that is not causal. It is more I'm there to help the patient. And so I did not ask all those questions and it is hard for him to answer questions that I don't ask. Really my concern for him was to help treat his symptoms.

Q. Right. And if a patient tells you that they hurt, do you have any way to confirm or prove that that's not the case?

A. No.

Q. In your experience do people come see the doctor and tell you they're hurting when they're not?

A. There are some that do.

Q. And what about undergoing surgery?

A. I hope no one would undergo surgery unless they had serious discomfort. I'm not certain but I would guess probably through the years there's been somebody that's had surgery that wanted to legitimize their complaints. But I think that's a really weird unusual person.

Q. Yeah.

A. For which I will say Mr. Walker is not.

Q. All right. Let me ask about range of motion following his surgery that you did on him in August of 2013.

MS. TAYLOR: If I may object. I didn't ask him about that.

MR. DEVINE: Perhaps you didn't but you'll have the opportunity to redirect or recross. Your objection stands.

BY MR. DEVINE:

Q. Did the surgery that you did for him affect his range of motion?

A. The surgery would affect the range of motion of a normal neck. I think we already established he had some degenerative changes. And unfortunately, again, I didn't examine him -- I say unfortunately only because we're doing a deposition -- but I didn't have the opportunity to ever examine him before he had the injury, so I really couldn't make comment on what kind of range of motion he had before.

But in the sense of doing a two-level fusion, it takes away about 15 percent of the motion of a normal spine. So he did have some motion still in those areas. So how much additional loss of motion that occurred is almost hard to quantify. But certainly it did occur.

Q. If he decides to go forward with another surgery involving a fusion, would you expect that

to further reduce his range of motion?

A. It will. It will probably, again assuming a normal spine, it would take away about 7 and a half to 8 percent of the extremes of his motion. Because each disc level imparts about 7 and a half to 8 percent of the motion of the spine.

Q. And just in terms of mobility of the neck, what sort of activities does that limitation impact?

A. That's more symptom driven than anything else. So I mean obviously there are some things that will be more difficult. You know, if you were trying to -- and I say this only because I've treated professional athletes -- I did a two-level fusion on a hockey player. It is very hard to skate and look back when you're skating because I guess we all know hockey they skate backwards. So that makes it more difficult for things like that. But knowing that he's not going to do that.

But otherwise, no symptoms of pain means he can participate in anything he likes. And the flipside is is, you know, Peyton Manning had a single level fusion in his neck and he won the Super Bowl. So a fusion in and of itself can impart significant stability to the neck to allow

someone to resume their normal activities. But again, it has to be symptom driven. If you got symptoms of pain, then I presume you'll use that information and not do whatever activity is that's causing the pain. Makes a lot of sense. On the other hand, if you don't hurt, then by all means do whatever you like.

MR. DEVINE: Understood. Nothing further.

MS. TAYLOR: Nothing further.

THE VIDEOGRAPHER: This concludes the video deposition of Dr. Daniel Silcox. We're off the record at 5:36 p.m.

(Deposition concluded at 5:35 p.m.)

(Signature waived)

The following reporter and firm disclosures were presented by me at this proceeding for review by counsel:

REPORTER DISCLOSURES

The following representations and disclosures are made in compliance with Georgia Law, more specifically:

Article 10 (B) of the Rules and Regulations of the Board of Court Reporting (disclosure forms)

OCGA Section 9-11-28 (c) (disqualification of reporter for financial interest)

OCGA Sections 15-14-37 (a) and (b) (prohibitions against contracts except on a case-by-case basis).

- I am a certified court reporter in the State of Georgia.
- I am a subcontractor for Veritext Legal Solutions.
- I have been assigned to make a complete and accurate record of these proceedings.
- I have no relationship of interest in the matter on which I am about to report which would disqualify me from making a verbatim record or maintaining my obligation of impartiality in compliance with the Code of Professional Ethics.
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- Transcripts: The transcript of this proceeding as produced will be a true, correct, and complete record of the colloquies, questions, and answers as submitted by the certified court reporter.
- Exhibits: No changes will be made to the exhibits as submitted by the reporter, attorneys, or witnesses.

- Password-Protected Access: Transcripts and exhibits relating to this proceeding will be uploaded to a password-protected repository, to which all ordering parties will have access.

CERTIFICATE

STATE OF GEORGIA:
COUNTY OF FULTON:

I hereby certify that the foregoing transcript was taken down, as stated in the caption, and the colloquies, questions and answers were reduced to typewriting under my direction; that the transcript is a true and correct record of the evidence given upon said proceeding.

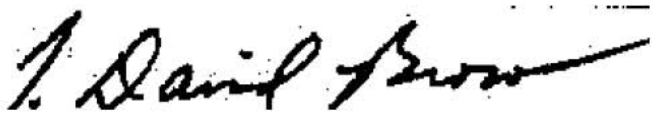
I further certify that I am not a relative or employee or attorney of any party, nor am I financially interested in the outcome of this action.

I have no relationship of interest in this matter which would disqualify me from maintaining my obligation of impartiality in compliance with the Code of Professional Ethics.

I have no direct contract with any party in this action and my compensation is based solely on the terms of my subcontractor agreement.

Nothing in the arrangements made for this proceeding impacts my absolute commitment to serve all parties as an impartial officer of the court.

This the 18th day of August, 2016.



J. DAVID BROWN, CCR-B-1401

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